

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : CHIGOZIE FRANCIS ONWUASOANYA

Card No : I040-029-117072633-01

Policy Holder : CHIGOZIE FRANCIS ONWUASOANYA

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Male

Date Of Birth : 04-Sep-1990

Patient's Tel No : 971555429234

Service Date :09-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Enomen Goodluck

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : Generalized body itching yellowness of the eyes

Duration :

Vitals:Temp : 36.7 Bp :109 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: K83.1 - Obstruction of bile duct,L29.9 - Pruritus, unspecified,R17 - Unspecified jaundice,

Date of Onset :09/02/2024

Requested Investigations: 80076, HEPATIC FUNCTION PANEL,85025, BLOOD COUNT COMPLETE

Estimated Cost :

AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP

Estimated Cost :

Prescriptions: 1111-183201-0391 - (FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS,

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :

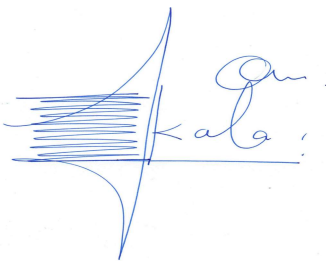
Dr. Enomen Goodluck Ekata

General Practitioner

DHA No: 28040827-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :

Date : 09-Sep-2024

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Patient 's signature{Parent : if minor}



Date : Sep-2024